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County of San Diego, California

Auditor and Controller

Final Report

California Children Services Program Audit

Office of Audits & Advisory Services

February 2009
Report No. A09-007

COUNTY OF SAN DIEGO

INTER-DEPARTMENTAL CORRESPONDENCE

February 26, 2009

TO: Donna Hand, Deputy Director
Health & Human Services Agency

FROM: Kenneth J. Mory
Chief of Audits

FINAL REPORT: CALIFORNIA CHILDREN SERVICES PROGRAM AUDIT

Enclosed is our report on the California Children Services Program Audit. The report includes various audit findings and recommendations.

We have reviewed your responses and have attached them to the audit report. The actions taken and planned, in general, are responsive to the findings and recommendations in the report. As required under Board Policy B-44, we respectfully request that you provide quarterly status reports on the implementation progress of the recommendations.

If you have any immediate concerns about the report, please contact me at (858) 495-5662.

KENNETH J. MORY
Chief of Audits

AUD:TP:aps

Enclosure

c: Nick Macchione, Director, HHSA
Donald F. Steuer, Chief Financial Officer
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Paula Landau-Cox, Deputy Director, HHSA
Terry Hogan, Group Finance Director, HHSA

AUDIT SCOPE AND LIMITATIONS

The Office of Audits & Advisory Services (OAAS) completed an audit of the California Children Services (CCS) program (the "Program") in accordance with the County's approved FY 2008-09 audit plan. The objective is to assess the management controls to ensure the program performs in accordance with State mandates. The audit covered FY 2006-07 to the current year.

The scope of the audit included all processes and services defined within the California Code as well as the guidelines established by California Medical Services (CMS). Additionally, the scope included all activities performed by or on behalf of the CCS program directly related to the Program's mission and purpose.

To more clearly define Program mandates, County Counsel and State representatives were consulted to determine if State requirements not included in California Code (e.g., the CMS Plan and Fiscal Guidelines and the State numbered letters) should be considered within the scope of a program mandate. It was concluded these requirements represent mutually agreed upon procedures necessary to fulfill the mandates under the supervision of the State. Thus, some key requirements not specified in California Code (but contained in the CMS Plan) were included within the scope of audit testing.

This audit was conducted in accordance with auditing standards prescribed by the Institute of Internal Auditors, Inc., as required by California Government Code, Section 1236.

METHODOLOGY

OAAS implemented a multi-faceted methodology to audit the Program. The following briefly describes the methods used:

- Performed a review of related mandates, codes, and regulatory requirements;
- Evaluated available reviews, studies, and audits related to the Program;
- Conducted interviews with key Program personnel and stakeholders;
- Reviewed processes, procedures, and desk manuals;
- Performed a financial and staffing trend analysis;
- Assessed Compliance with Mandates with the following methods:
    - Tested a sample of administrative cases for conformance with mandates;
    - Tested a sample of CCS-only cases for compliance with fee collection requirements;
    - Tested a sample of eligibility appeals for conformance with regulatory requirements;
- Assessed management control through the following methods:
    - Performed validation testing (re-performance) of Quality Assurance reports;
    - Verified the existence of select key controls;
    - Performed a general assessment of management controls.

OVERVIEW OF THE SAN DIEGO COUNTY CCS PROGRAM

In San Diego County, the CCS Program provides administrative and medical therapy services for approximately 16,000 children throughout the County. In FY 2007-08, the Program's budget included 155 Full-time Equivalent Employees (FTE) and a budget of approximately $21.6M. For additional background information on the CCS Program, including funding sources, see Appendix B.

Chart 1 illustrates how staffing for the Program has increased over the past five years. The increase in staffing occurred primarily in response to standards established by the State based on caseload. Staffing increases included a change in Public Health Nurses (PHN) from 16 to 25 FTEs (56% increase), while all other position increased from 117.25 to 121.75 FTEs (4% increase).

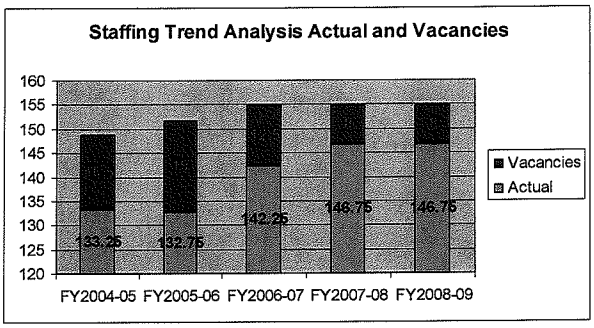

Chart 1

The Program's structure is organized by service type. CCS Administration (78 FTEs) utilizes a team structure of 16 teams, with caseload distributed by patient name. Each team includes a PHN, a Health Services Specialist (HSS), and an Office Administrator (OA). The MTP program includes 72.75 FTEs in 6 MTU locations.

The Program has also experienced an increase in caseload. While the MTP caseload has remained relative constant, the CCS Administrative caseload, as illustrated in Chart 2, experienced an increase in quarterly average caseload of approximately 18% over the past three fiscal years to approximately 14,000 pending and active cases.

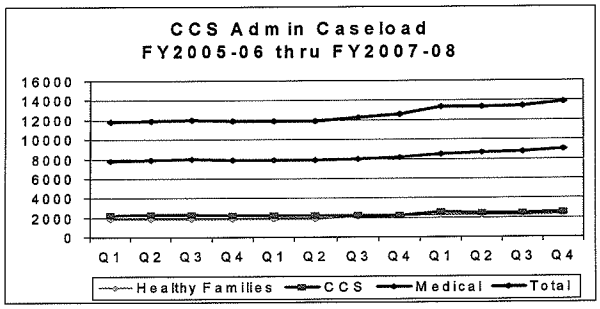

Chart 2

The Program budget also experienced a corresponding increase in expenditures. Chart 3 shows that from FY 2004-05 through FY 2006-07, expenditure increases were offset by an increase in revenues. However, in FY 2007-08, revenues remained relatively constant while expenditures continued to increase, resulting in a spike in the need for general fund revenues. This will be discussed in greater detail later in the report.

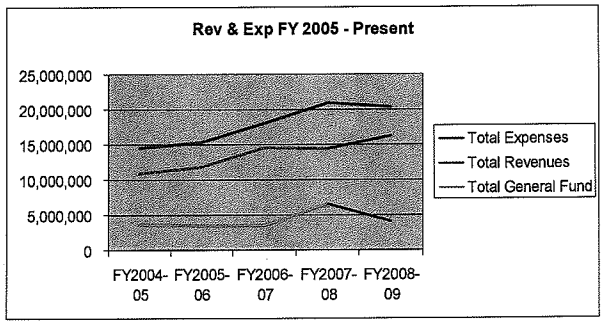

Chart 3

FINDINGS

Audit work revealed that, within the scope of the audit, the Program was generally compliant in fulfilling the legal and regulatory requirements as established by State mandates and that adequate management controls were in place for the achievement of Program objectives. Opportunities for improving and strengthening of management controls are provided in the following findings and observations.

Finding I: EDS Claims Monitoring Discontinued, Requirement Unclear

It was observed that monitoring of Electronic Data Systems (EDS) claims by the Accounting Clerk (AC) had been discontinued. It was reported that monitoring had been halted at the direction of the former Program Chief; however, monitoring was still included as a role of the AC in the CCS Administrative Manual. Monitoring logs maintained as recently as October 2007 included billing discrepancies (funding categorizations) that had been detected by accounting staff, but no action had been taken or requests made to correct. Program administration personnel indicated that they believe the monitoring had been ceased due to the belief that system (EDS) controls were adequate, thus eliminating the need to perform the monitoring activity. As a test of system controls, the Program was asked to verify that 30 discrepancies detected in 2007 had been identified and corrected by the system. The Program subsequently reported that they were unable to determine if the corrections/adjustments had been made. Due to the varying rate of County contribution by case type, incorrect categorization that goes undetected and/or uncorrected can represent a significant avoidable cost to the Program.

Finding II: Improvement in Records Management Needed

One recurring issue encountered during the audit involved the records management system and availability of supporting documentation. Issues encountered include retention of required documentation, adequate documentation of supporting information, and organization and availability of required documents.

Records Retention Policy – During the course of audit testing, it was observed that some supporting documentation had been purged after only one year. Specifically, staff had purged temporary (denied) case files related to the appeals process. While the Program indicated that there was no requirement for maintenance of temporary case files, elements of the case files (e.g., signed CCS applications and Notice of Action Letters) are official documents that fall under the County and HHSA document retention policies and should be retained for at least five years.

Incomplete Supporting Documentation – Testing of case files revealed multiple occurrences where inadequate supporting documentation was maintained (See test results in Appendix A). Examples include records supporting service delivery time thresholds, evidence supporting family size, and justification for cost of care eligibility determination. While cost of care documentation in case files or CMSnet database entries consistently included a calculation for 20% of gross income, an itemized list of estimated costs exceeding the 20% could not be identified in four cases reviewed. Staff demonstrated that a form had been created for that purpose but was not utilized. Cost of care is a specific eligibility criterion and should be included in the case file information in support of the determination.

Availability of MOU Documentation – Audit work revealed that not all of the signed copies of the Program's Memoranda of Understanding (MOU) could be located and that it was not clear whether all MOU were accurately reported to the State. Each year, the State requires that a list of all active MOU for the program be provided with the Program application package. Upon inspection of the documentation provided, not all MOU listed were present and in one case, an MOU with the Healthy Families program was not on the State list of MOU. The Program was unable to provide evidence of the completeness of the list or the actual location of all signed MOU listed. Recent administration turnovers, as well as the organization of records are contributing factors. Retention of signed MOU by the Program is a State requirement.

Finding III: Significant Variations in QA Test Results

Audit work revealed significant variations in QA test result with no clear targets or control limits. QA data contained in monthly management reports was analyzed to assess overall performance against mandate criteria over time. Chart 4 shown fluctuations in both administration and clinical QA results (% full compliance) of over 30% within the scope of the audit. Staff turnover and learning curves were cited as the primary cause of increased percentage of discrepancies detected. In addition to the QA testing results, monthly reports include comments on error trends, analysis, and corrective actions. However, the results over time indicate that the controls utilized have not been consistently effective.

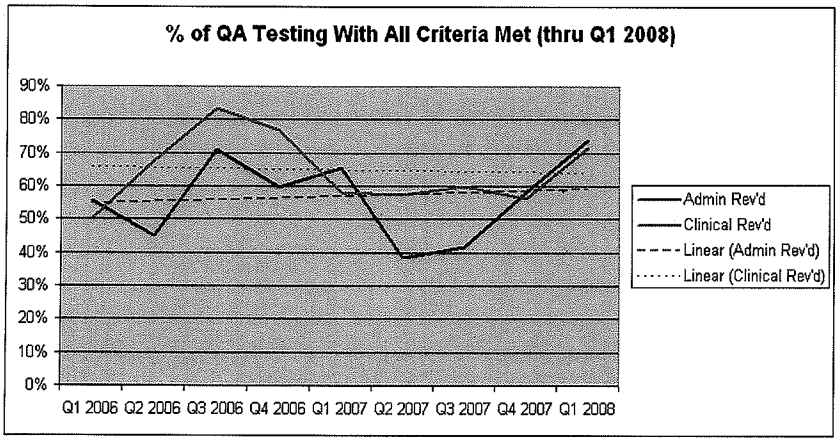

Chart 4

Reliability of the QA test results was also assessed through re-performance testing of a random sample of 27 cases where QA had been performed. A total of19 mandates/requirements were tested with three exceptions identified where QA did not match the audit results, including:

- Medical Home (2); and
- Timeliness criteria (1).

Total mandates/requirements tested	19
Total cases in the sample	27
Total tests performed	476
Total exceptions observed	3
% Exceptions	0.6%
# of cases with exceptions	3
% cases with exceptions	11.1%

QA test results and follow up activity were documented and reported; however, QA test procedures and test criteria were not clearly documented. While the exceptions represent a low overall variance rate (0.6%), the relatively high percentage of cases with variances (11.1%) does have an impact on the accuracy of the overall compliance results reported and would reduce the percentage of cases in full compliance. QA activities are not a State program requirement, but they represent key program management controls that ensure compliance and service level objectives are achieved.

Finding IV: Program Certification Performed Outside of Program Accountability

A review of required documentation revealed that the certification of the CCS program was performed by the County Public Health Officer, a position not within the line of executive accountability for program operations. Program certification should include co-signature by an executive director with accountability for the program. A space is provided on the State form but has not been utilized. Note: Prior to the issuance of this report, HHSA had announced that the CCS program will soon be reporting to Public Health Services under the Public Health Officer.

RECOMMENDATIONS

Recommendation I: Reassess the monitoring requirements for EDS claims and modify the CCS Administrative manual to reflect the monitoring roles and the role of the AC position. A review and update of the entire CCS administrative manual is recommended due to recent management turnover.

Recommendation II: Perform a review of records retention policies and procedures to ensure compliance with the County and HHSA policies. Modify and communication document retention and purging policy to staff involve with records maintenance. Develop a method for retaining official records for temporary files, including signed applications and notices of action.

Recommendation III: Perform a review of all active MOU and ensure that copies of all signed MOU are maintained on site and readily available

Recommendation IV: Ensure that documentation associated with cost of care eligibility is fully documented with actual estimated costs itemized.

Recommendation V: QA procedures should be documented to ensure that clear inspection criteria are consistently utilized. Additionally, an analysis should be conducted to identify key controls to address compliance error rate fluctuations.

COMMENDATION

The Office of Audits & Advisory Services commends and sincerely appreciates the courteousness and cooperation extended by the officers and staff of the California Children Services Program, the HHSA North Coastal Region Executive Office, and the HHSA Financial Services Support Division throughout this audit.

AUDIT TEAM

Tom Philipp, Supervising Senior Auditor-IA
Kathleen Whitehead, Auditor I

Appendix A
Test Results and Audit Observations

The following test results and audit observations are provided in the areas of program compliance and management controls.

COMPLIANCE TESTING

Observation I: Program Generally Compliant with State Mandates

Audit work revealed that the Program is generally compliant with State mandates and requirements. Mandates for the program are primarily found in the Health and Safety Code (H&S)[1] and the California Code of Regulations (CCR). A comprehensive list of Program mandates and state requirements is contained in the CMS Plan and Fiscal Guidelines produced by the State annually.

Audit testing involved both direct observations and substantive testing. A judgmental sample of mandates and requirements were selected for testing based on program risk. A summary of mandates and requirements utilized in audit testing in provided in Appendix C. Substantive testing was performed in the areas of: CCS Administration compliance, the appeals process, and fee collections with the following results.

CCS Administration Compliance Testing

Compliance testing involved inspection of a random sample of 36 case files against a range of 29 mandates/requirements. A total of ten exceptions were identified, including:

- Medical Home not identified (5);
- Timeliness criteria (3);
- Residency determination (1); and
- Transition planning (1).

Total mandates/requirements tested	29
Total cases selected for testing	36
Total tests performed	423
Total exceptions observed	10
% Variance	2.4%
# of cases with variances	10
Areas Inspected with Exceptions	5

Of the exceptions identified, nine involved service level requirements and one (residency) was related to eligibility determination. The cause cited by management for the majority of the exceptions involved staff turnover and learning curves.

Appeals Process Testing

Appeals process compliance testing involved inspection of a random sample of ten appeals cases against a range of five mandates. A total of seven exceptions were identified, all related to maintenance of appeals documentation. Exceptions included six occasions where Notice of Action (NOA) letters were not maintained and one case where supporting documentation to

Total mandates/requirements tested	5
Total cases selected for testing	10
Total tests performed	50
Total exceptions observed	7
% Variance	14%
Areas Inspected with Exceptions	1

[1] The primary enabling legislation mandating the program in found in H&S Section 123800-123995, known as the Robert W. Crown California Children's Services Act.

confirm compliance with a 30 day response time was not available. A primary cause of the documentation issues identified is related to document retention policies reported in Finding II.

Fee Collection Testing

Fee collection compliance testing involved inspection of a random sample of 13 CCS-cases against a range of five mandates/requirements. While all mandates were met, in two cases adequate supporting documentation was not found supporting the family size utilized in the fee calculations.

Total mandates/requirements tested	5
Total receipts/cases selected for testing	13
Total tests performed	65
Total exceptions observed	2
% Variance	3.1%
Areas Inspected with Exceptions	1

Observation II: Staffing Standards Not Met

It was observed that despite the increase in staffing reported previously, staffing standards established by the State were not met during the period under review. The CMS Plan indicates that in order to meet H&S Code requirements in Section 123955 CCS, program staffing must be established at levels based on County's case load. The standard for the ratio of PHN to caseload is established at 400:1 and remained at that level in the FY 2008-09 State Plan. As of September 2008, the PHN ratio reported by the Program was 636:1. Both the Program Chief and State CMS regional representatives indicated that despite the CMS Plan guidelines, San Diego's staffing levels were deemed adequate through State approval of the County's annual application package.[2] CMS representatives further stated that the new IT systems have introduced efficiencies that allowed higher staff ratios without sacrificing service response time and that the staffing standards need to be revisited. Monthly CCS management reports include actual and required staffing standards for PHNs.

MANAGEMENT CONTROLS

A risk-based approach was utilized for the management controls assessment starting with a risk assessment involving program management. Management identified the following key risks associated with program objectives:

- Suspended Provider Payments;
- Increased General Fund Burden;
- Incorrect claims classification;
- Availability of skill workforce and staff turnover;
- Litigation;
- Public Relations; and
- Inability to meet service level requirements

With these program risks considered, a judgmental sample of key controls was selected and tested, including: budgeting and expense management, quality assurance procedures, staffing and succession planning, claims monitoring, and records management.

[2] Annually the program submits an application package that includes staffing levels and other service level and performance standards. According to state representatives, subsequent budget approval and allocations represents an implicit agreement that the conditions within the application package adequately comply with state requirements.

Observation III: General Fund Exceeded Budget in FY 2007-08

A review of financial results over the past four years revealed a sharp increase in general fund revenues in FY 2007-08, exceeding the amount budgeted by approximately $400K. For each of the past four years, revenues have been under budget; however, the expenditure savings have offset the revenue variance. The increase in general fund burden resulted from a combination of lower than expected revenues and higher expenditures in several key areas as summarized below.

Revenue Variance – Two primary factors affecting the revenue variance were identified: funding for development of the EQuest referral system and less than anticipated revenues in revenue account 45204 (State Medi-Cal). In FY 2007-08, the Program was allocated costs of approximately $670K for the EQuest system; however, there were no revenues received at the Program level. A request for funding for inclusion in the CMS annual budget allocation was rejected by the State, and HHSA Business Process Reengineering (BPR) funds allocated for EQuest were not transferred to the Program level. State funding for EQuest would have reduced, but not eliminated, the variance in intergovernmental revenues (including acct. 45204) which have been underestimated for the past three fiscal years.

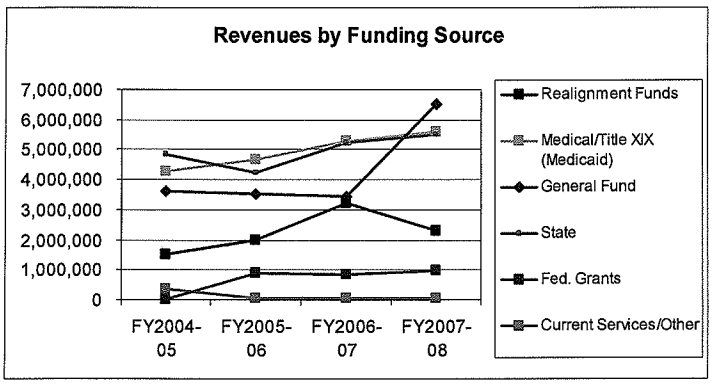

Chart 4

Expenditure Variance – Between FY 2006-07 and FY 2007-08, Program expenditures increased from approximately $18M to $20.9M. Approximately 98% of the increase can be attributed to five factors: support and care costs (34%), salary and benefits increases (26%), IT costs (23%), retirement benefits (14%); and contracts (3%). Support and care expenditures are directly correlated to the quantities and types of client treatments requested and are subject to fluctuations outside of the Program's control. Salary and Benefits increases were impacted by adjustments made following a salary study performed by the Department of Human Resources. The largest portion or the IT increase was related to the EQuest referral system currently under development.

As of the 3rd quarter fund balance report (April 2008), the Program's net costs were still projected as favorable. This was primarily due to a projection of support and care costs that was $1.1M below the year end totals.

Observation IV: High Administrative Staff Turnover

During the course of the audit, high staff turnover (one of the key risks identified) was experienced in the area of Program administration. Within a short period, three key persons directly involved with Program's administration retired: the Program Administrative Manager, the Program Chief, and the Assistant Deputy Director (North Coastal Region). This represents a major loss of institutional knowledge, especially with the position of the Program Chief. The

Program Chief performs many of the key control activities related to the Program's key risks as shown in the following table.

Key Control Activity	Risk Mitigated
Monitoring of available provider funding.	Insufficient funding is available to pay provider claims through the end of the budget year (suspended provider payments).
Maintenance of relationships with providers and state representatives, including: negotiating with providers for share of cost payments, or requesting adjustment of state allocations.	Insufficient funding is available to pay provider claims through the end of the budget year (suspended provider payments).
Claims/Expense Monitoring to identify spikes or unexpected variances. Notifying region and fiscal of possible revenue or expenditure variances.	Negative fund balance projections.
Monitor claims data for high impact cases. Ensure eligibility is confirmed and categorization is correct for CCS-only and HF cases.	Incorrect categorization and avoidable costs.
Program liaison with state and external agencies.	Economic, medical, or legislative changes that could adversely affect the Program.
Avoidance of appeals cases, self-representation of appeals cases.	Avoidable cost for counsel representation.
Succession Planning and Procedure Documentation.	Discontinuity of program operations inadequate staff skills and knowledge of key controls.

The impact of high turnover is mitigated by factors such as the adequacy of documented policies and procedures, succession planning, and the effectiveness of training and development. Additionally, organizational assessment activities such as the HHSA Management Controls Initiative (MCI) could serve to accelerate the learning curve of new administrative managers.

Appendix B
Introduction and Background

The California Children Services (CCS) program provides diagnosis, treatment services, medical case management, and physical and occupational therapy services to individuals under age 21 with CCS-eligible medical conditions whose families are unable to pay for all or part of their care. Examples of CCS-eligible conditions include chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases. (For a list of medically eligible conditions, see Appendix D)

Children eligible for CCS must be residents of California, have CCS eligible conditions, and have family adjusted gross income of $40,000 or less in the most recent tax year. Children in families with higher incomes may still be eligible for CCS if the estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

The program provides two types of services: CCS administration and medical therapy.

CCS Administration – Provides medical case management activities including: determining program eligibility, evaluating needs for specific services, assuring appropriate providers, and authorizing medically necessary care.

Medical Therapy Program (MTP) – Provides physical therapy, occupational therapy, and medical therapy conferences (MTC) services to children who meet specific medical eligibility criteria. These services are provided in an outpatient clinic setting known as a Medical Therapy Unit (MTU) that is located on a public school site. Licensed physical therapists and occupational therapists provide evaluation, treatment, consultation services, and case management to children with conditions such as cerebral palsy and other neurological and musculoskeletal disorders.

Funding is dependent on the specific program in which the children are enrolled: Medi-Cal, the Healthy Families program,[3] or CCS-only (for those not covered by Medi-Cal or Healthy Families). Funding ratios and case load percentages in San Diego County are shown below.

Funding Source	% of Caseload	Funding Source
Medi-Cal	64.4%	100% Federal and State
Healthy Families	16.8%	82.5% Federal and State 17.5% County
CCS-Only	18.8%	50% State 50% County

[3] The California Healthy Families Program is low cost insurance that provides health, dental and vision coverage to children who do not have insurance and do not qualify for Medi-Cal.

Appendix C
Summary of Mandates/Requirements

Code/Section	Summary Description
H&S Section 123805 CCR §41510, §41512	CCS is limited to persons under 21.
H&S 123855	CCS shall seek out handicapped children through local public and private agencies, bringing expert diagnosis near their homes.
H&S Section 123860	Diagnosis will be provided.
H&S Section 123865 CCR § 41900, GC 244	Residency shall be determined and recorded.
H&S Section 123870 H&S Section123895	CCS applicants must have an adjusted gross income of $40,000 or less. Higher incomes may qualify if the cost of care exceeds 20% of family income.
H&S Section 123900 CCR §42115	All CCS applicants shall pay an annual enrollment fee based on a sliding fee scale upon family size.
H&S Section 123925	Surveillance and supervision over the services shall be provided and case records maintained.
H&S Section 123929 NL 02-0301 (2001) WIC Section 14133.05	Prior authorization is required for all CCS services. If the applicant has Healthy Families or Medi-Cal, prior authorization is waived.
H&S Section 123950	Parent/guardian must sign written consent for any treatment services.
IC Section 12693.62	Case Management and authorization should be performed by CCS. Diagnosis and treatment services should be performed by a CCS paneled provider.
NL 06-0394 (1994)	All insurance must be reported at time of application.
CCR §41518	Benefits authorized by CCS Program must be medically necessary.
CCR §41800	The determination of whether the child has a medical eligible condition must be made by a certified Public Health Nurse (PHN).
CCR §41811 thru §41876	Medical Eligible Conditions: Specifies 18 areas of medical eligibility.
NL 20-0997 (1997)	Medical Eligibility should be determined within five working dates of receipt of all medical documentation necessary.
CCR §42050	The determination of financial eligibility should be made within 30 days of receipt of documentation. The 30 day timeline may be extended if referred to Medi-Cal.
CCR §42110	Parents must be provided notification of residential and financial eligibility, annual enrollment fee, effective dates, due date for annual enrollment fee, and agreement in regards to outside insurance.
CCR §42125	CCS shall retain the original of the legal agreement part of the financial eligibility and enrollment fee determination worksheets. Specific guidelines provides for case closure due to failure to pay.
CCR §42180	Prior authorization is required and a record of authorizations shall be retained.
CCR §42321, CCR §42326	Medical treatment must be performed by a CCS paneled provider.
CCR §42701	A written notice of action shall be sent to the applicant, client and/or legal guardian, or authorized representative within seven calendar days of the decision by the designated CCS agency (reasons specified).
CCR §42703	First Level Appeals starts when the CCS client is not satisfied with a decision and may submit a written appeal within 30 calendar days from the date of the Notice of Action. The written appeal shall provide pertinent information including request for continuation of CCS services during appeal process. Within 21 calendar days of receipt of the written appeal, CCS shall review the appeals and mail the written response with the basis of the decision.
CCR §42705	An applicant whose appeal has been denied may request a CCS Fair Hearing. A written request shall be filed with the Department of Health Services within 14 calendar days of the written appeal decision and shall be signed by applicant.

Appendix D
Summary of Medically Eligible Conditions

	Medically Eligible Conditions	Example
1	Infectious Disease	Bone infections
2	Neoplasms	Leukemia
3	Endocrine, Nutritional, and Metabolic, and Immune Disorders	Growth hormone deficiency
4	Disease of Blood and Blood-Forming Organs	Anemia
5	Disease of the Nervous System	Cerebral palsy
6	Disease of the Eye	Cataract
7	Disease of the Ear and Mastoid Process	Poor speech due to hearing loss
8	Disease of the Circulatory System	Hypertension that requires medication
9	Disease of the Respiratory System	Cystic fibrosis
10	Disease of the Digestive System	Acute liver failure
11	Disease of the Genitourinary System	Obstructive uropathies
12	Disease of the Skin and Subcutaneous Tissues	Scars when surgery is required and severely disfiguring
13	Disease of the Musculoskeletal System and Connective Tissue	Chronic infections of the joint
14	Congenital Anomalies	Congenital anomalies limits a body function
15	Perinatal Morbidity and Mortality	Emergency Operation
16	Accidents, Poisoning, Violence, and Immunization Reactions	Poisonous snake bites
17	Pediatric Intensive Care	Intensive Care Unit

Note: *Medical Therapy Program has been excluded from this list.*

DEPARTMENT RESPONSE

County of San Diego

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February 24, 2009

TO: Kenneth J. Mory
Chief of Audits

FROM: Donna Hand, Deputy Director
Health and Human Services Agency
North Regions

REPORT: PLAN OF CORRECTION FOR CALIFORNIA CHILDREN SERVICES PROGRAM

Enclosed is the report for the Plan of Correction for the California Children Services (CCS) program.

Per Board of Supervisor Policy B-44 a written response addressing audit findings and recommendations is required. This Plan of Correction Report includes actions taken or planned in response to the audit report.

Thank you for the opportunity to address issues regarding the CCS program. Continuous improvement along with appropriate monitoring and control procedures ensure the highest standard of service to the residents of the County of San Diego.

DONNA HAND
Deputy Director

Plan of Correction
California Children Services
February 24, 2009

This Plan of Correction is in response to the findings and observations documented on the Audit of California Children Services (CCS), Report No. A09-007, completed February 2009.

Finding I:

EDS Claims Monitoring Discontinued, Requirement Unclear

Plan of Correction:

Effective immediately the CCS administrative manager will review Electronic Data Systems (EDS) claims for possible billing discrepancies. Billing discrepancies will be noted and a written request for correction of discrepancies will be sent to EDS for resolution of the discrepancy. The administrative manager will maintain appropriate records to track the discrepancies and verify that timely resolution was achieved. The CCS administrative manual will be updated to reflect the monitoring roles and procedures for resolution of any billing discrepancies by the end of Fiscal Year 08/09.

Finding II:

Improvement in Records Management Needed

Plan of Correction:

- Records Retention Policy – A review of County of San Diego and Health and Human Services (HHSA) retention policies has been implemented by the administrative manager, office support staff and other appropriate personnel by the end of Fiscal Year 08/09. The review will ensure that staff is educated on the County and HHSA document retention policies. Official documents that fall under these policies will be retained in compliance with established County and HHSA retention polices. Written policies and procedures for retention and purging of files will be developed and random audits performed to ensure compliance with County and HHSA policies.
- Incomplete Support Documentation – The CCS administrative manager shall ensure that staff retains all necessary documentation supporting eligibility determination. Staff will implement usage of appropriate documentation to support cost of care eligibility determination; documentation will include an itemization of estimated costs that will be maintained in the official case file.
- Availability of Memorandum of Understanding (MOU) Documentation – A review of all existing MOU is continuing and will be completed by the end

of the Fiscal Year 08/09. The CCS administrative manager will verify with the State of California that a list of all active MOU is on file with the State. All signed copies of MOU will be collected and stored on site by the end of Fiscal Year 08/09.

Finding III:

Significant Variations in Quality Assurance (QA) Test Results

Plan of Correction:

The CCS administrative manager will ensure that appropriate supervisory staff review and update policies and procedures related to inspection criteria and testing procedures for QA by the end of Fiscal Year 08/09. A method of documenting completion of regular QA testing with clear inspection criteria will be part of the policies and procedures implemented. Appropriate training of new staff and on-going training will be developed and implemented by the end of Fiscal Year 08/09. A methodology of analyzing the results of all QA testing will be developed to identify key controls addressing compliance error rate fluctuation.

Finding IV:

Program Certification Performed Outside of Program Accountability

Plan of Correction:

The CCS program has been moved within the HHSA organizational structure to address program accountability. CCS is now organized under Public Health Services under the direction of the County Public Health Officer. Certification of the CCS program is now in line with executive accountability.